



NY Paid Family Leave: Employee Opt-out

Information on the option to opt-out of paid family leave can be found at the bottom of this form.

Employer Information	
EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA) GEP Cencast, LLC dba Central Casting	
ADDRESS	EMPLOYER FEIN
CITY, STATE and ZIP CODE	TELEPHONE NUMBER
Employee Information	
EMPLOYEE NAME	LAST 4 of SSN XXX - XX -
HOME ADDRESS	EMAIL ADDRESS
CITY, STATE and ZIP CODE	TELEPHONE NUMBER
Employee Affirmation	
<p>1. I would like to waive paid family leave coverage at this time because (select one):</p> <p><input type="checkbox"/> I regularly work 20 hours or more per week, but will not work 26 consecutive weeks (6 months) for this employer.</p> <p><input type="checkbox"/> I regularly work less than 20 hours per week, but will not work 175 days in 52 consecutive weeks (a year) for this employer.</p> <p>2. I understand that I will need to revoke this waiver and opt in to paid family leave coverage if my work schedule changes and it is anticipated I will work more than 20 hours per week for 6 months, or will work less than 20 hours per week but at least 175 days in a 52 consecutive week period (1 year).</p> <p>3. I understand that this waiver is OPTIONAL AND REVOCABLE</p> <p>(a) My employer may not force me to opt out of paid family leave benefits.</p> <p>(b) I may decide later to revoke this waiver even if my schedule does not change.</p> <p>4. I also understand if this waiver is revoked by me either as my preference or due to a change in my work schedule, my employer may take retroactive deductions for the period of time I was covered by this waiver, and this period of time counts towards my eligibility for paid family leave.</p>	
Certification I certify to the best of my knowledge the foregoing statements are complete and true.	
Employer's Signature: _____	Date Signed: _____
Employee's Signature: _____	Date Signed: _____

Please note: Employer must keep a copy of the fully executed waiver on file for as long as the employee remains in employment with the covered employer.

Submit completed form and/or email questions to nypfl@ep.com.

Opting Out of Paid Family Leave (12 NYCRR 380-2.6)
<p>(a) An employee of a covered employer shall be provided the option to file a waiver of family leave benefits:</p> <p>(i) When his or her regular employment schedule is 20 hours or more per week but the employee will not work 26 consecutive weeks, or</p> <p>(ii) When his or her regular employment schedule is less than 20 hours per week and the employee will not work 175 days in a 52 consecutive week period.</p> <p>(b) This waiver will be applied to all projects payrolled by Central Casting that the employee opting out works on prospectively from the date form is received by Central Casting. Employees seeking to opt back in must first contact EP Benefit Solutions and repay (either up-front or through paycheck deductions) the NY Paid Family Leave contributions that otherwise would have occurred and been deducted from the employee's paycheck(s) during the time period covered by the opt-out form; such period of time would count towards the employee's eligibility once opted back in to NY Paid Family Leave.</p> <p>(c) The covered employer shall keep a copy of the fully executed waiver on file to be produced at the request of the Chair, for as long as the employee remains in employment with the covered employer.</p> <p>(d) An employee as described in Subsection (a) of this Section who elects not to enter into a waiver shall make regular family benefit contributions for the full duration of his or her employment with the covered employer, and the covered employer shall be obligated to provide family leave benefits for such employee when he or she is eligible pursuant to this Title.</p>